

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-2)

0726-282

CERTIFICATE OF DEATH

Reg. Dist. No. 283

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred: St. Mary's Hospital

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male Colored

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

Feb. 14 - 1892

6. (c) If alive, give age.....

years

8. AGE: Years

Months Days If less than one day

64

4

26

.hrs.

min.

9. Birthplace.....

(Town, county, and state) Helen, St. Mary's, Md

10. Usual occupation.....

11. Industry or business

12. Name.....

B. Bailey & Barnes

13. Birthplace

14. Maiden name.....

Margaret A. Thomas

15. Birthplace

16. Informant.....

James F. Barnes

Address

Helen, Md

17. Burial

(Burial, cremation, or removal, which)

Date thereof

July 18 - 1946

(month) (day) (year)

Cemetery or crematory

St. Joseph's Cemetery

Location

Morganza, Md

18. Funeral director

W. H. Manning, Funeral

Address

Baltimore, Md

19. Date rec'd by registrar

1946

Date signed

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 10 1946 at 11 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Helen 26 1946 to 1946, July 10 a.m. to 1946

and that I last saw her alive on Helen 26 1946 to 1946

Immediate cause of death.....

hemorrhage -

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

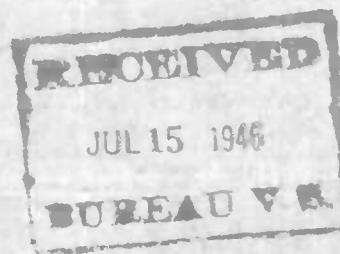
Injured at work?

23. SIGNATURE

J. B. Johnson
Morganza, Md

M. D. or other

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

07265

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

County St. MARY'S
 City or town LEONARDTOWN Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

St. Mary's Hospital, LeonardtownHow long in hospital or institution: TWELVE Hours.

3. (a) FULL NAME

JOHN FRANK PAULINE BRISCOE
 4. Sex FEMALE 5. Color or race Neoro 6. (a) Single, married, widowed, or divorced Single

8. (b) Name of husband or wife...

7. Birth date of deceased (mo., day, yr.) Dec. 1944 8. (c) If alive, give age years

8. AGE: Years 1 Months 0 Days 0 If less than one day
 hrs. 0 min. 0

9. Birthplace St. Mary's Co. Maryland
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

MOTHER FATHER John FRANK BRISCOE
 12. Name John FRANK BRISCOE
 13. Birthplace MARYLAND

MOTHER PAULINE MARY DABBING
 14. Maiden name PAULINE MARY DABBING
 15. Birthplace MARYLAND

16. Informant John FRANK BRISCOEAddress Chaptico, Md.

17. Burial (Burial, cremation, or removal, Which?) Cemetery Date thereof July 28 1946
 (month) (day) (year)

Cemetery or crematory St. Joseph's Cemetery
 Location St. Joseph's Cemetery -
Rose E. Welch.

18. Funeral director Rose E. Welch.
 Address Chaptico

19. 7/27/46 (Date rec'd by registrar) 1946 Registrar
 Address Chaptico Registrar Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MARYLAND County St. Mary's
 City or town Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Chaptico, Md.
 (If rural, give LOCATION)

2. (a) If veteran, name war...

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1946 at 12:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 1946 to July 26 1946, and that I last saw him alive on July 26 1946.Immediate cause of death Acute Bronchitis pneumonia (verus) 7/24/46 DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Data of op.

Autopsy results none done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Aloysius C. Welch M.D. M. D. or otherAddress Chaptico, Md. Date signed 7/27/46

RECEIVED BY THE TENNESSEE STATE HIGHWAY

DEPARTMENT OF TRANSPORTATION



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

07260

CERTIFICATE OF DEATH

Reg. Dist. No. 286

1. PLACE OF DEATH:

County: St. Mary'sCity or town: St. Mary's (If outside city or town limits, write RURAL and give nearest town)How long in above place of death? all his life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? _____

3. (a) FULL NAME

Paul Bernard Butler

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

in co. single

6. (b) Name of husband or wife: _____

7. Birth date of deceased (mo., day, yr.)

4-8-43

8. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

5 3 21 hrs. _____ min.9. Birthplace: St. Mary's

(Town, county, and state)

10. Usual occupation: carpenter

11. Industry or business

FATHER

12. Name: Paul Bernard and Butler13. Birthplace: Palermo

MOTHER

14. Maiden name: Sally Mary Carr15. Birthplace: Wash D.C.16. Informant: Paul B. Butler

Address

St. Mary's17. Burial, cremation, or removal. Which? BurialDate thereof: 4-30-46
(month) (day) (year)Cemetery or crematory: Sacred HeartLocation: St. Mary's18. Funeral director: Ron E. McElderry

Address

Cleopatra Mtn.

19. (Date rec'd by registrar)

19. (Date of death)

4-30-46

19. (Date of death)

4-30-46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: MdCounty: St. Mary'sCity or town: St. Mary's

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war: _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-29- 1946, at 3:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on dead 7-29-46 1946Immediate cause of death: Decomposition

accidental

Due to: Fall from wheelchair

Due to: _____

Other conditions: _____

(Include pregnancy within 3 months of death)

Major findings of operations: _____

Date of op. _____

Autopsy results: _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

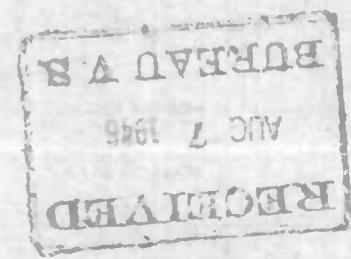
Means of injury

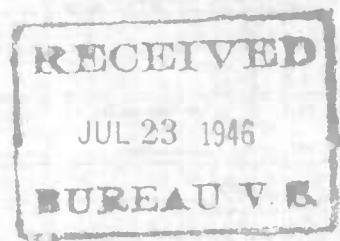
Injured at work?

23. SIGNATURE

Robert V Palmer M. D. or other

Address: St. Mary's Date signed: 4-30-46





M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

07269

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female colored married

6. (b) Name of husband or wife

James A. Grinnell

7. Birth date of deceased (mo., day, yr.)

Aug. 12, 1864

8. AGE:

Years Months Days If less than one day hrs. min.

81

11

16

years

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

John Biscoe

12. Name

John Biscoe

13. Birthplace

Maryland

14. Maiden name

Unknown

15. Birthplace

"

16. Informant

James A. Grinnell

Address

Ridge, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

St. Peters

Location

Ridge, Md.

18. Funeral director

J. B. Robinson

Address

Leonardtown, Md.

19. 7-29-

1946

(Date rec'd by registrar)

P. J. Scanlon
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1946 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 28 1946 to July 28 1946
and that I last saw her alive on July 28 1946

Immediate cause of death

Cerebral hemorrhage

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

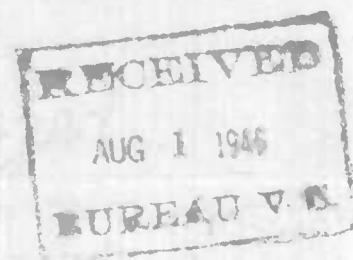
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Great Mills, Md. Date signed 7-29-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

07270

CERTIFICATE OF DEATH

Reg. Diat. No. 281

1. PLACE OF DEATH:

County

St. Mary's Park Hall

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

3. (a) FULL NAME

James Washington Haddock

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

6. (b) Name of husband or wife

Gertrude Haddock

7. Birth date of deceased (mo. day, yr.)

Sept. 15, 1845

8. (c) If alive, give age 59 years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Winston Va.

(Town, County, and state)

10. Usual occupation

Carpenter

11. Industry or business

J.W. Haddock

12. Name

Va.

13. Birthplace

Mary Smith

14. Maiden name

Va.

15. Birthplace

Holy Face

16. Informant

Gertrude Haddock

Address

Park Hall Md

17. Burial

Date thereof 7-15-46

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or cemetery

Great Mills Md

Location

P. B. Robinson

18. Funeral director

Leonardtown Md

Address

19. 7-13-46

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys

City or town Park Hall, Md. (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

July 13 1946 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 8 1946 to July 13 1946 and that I last saw him/her alive on July 12 1946

Immediate cause of death

Coronary sclerosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

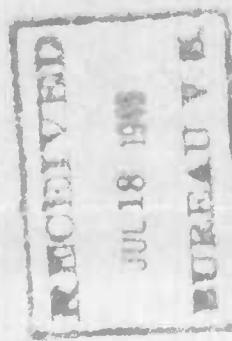
Injured at work?

23. SIGNATURE

P. J. Beary M.D.

M. D. or other

Address Great Mills, Md. Date signed 7-18-46



M

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

07271

CERTIFICATE OF DEATH

282

Reg. Dist. No.

1. PLACE OF DEATH

County

St. Marys

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, institution, or street address where death occurred:

St. Marys Hospital

How long in hospital or institution? 2 Days

3. (a) FULL NAME

John Woodley Morgan

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White married

6. (b) Name of husband or wife Mary M Morgan

7. Birth date of deceased (mo., day, yr.)

6 (c) If alive, give age 62 years

Feb 16 - 1883

8. AGE: Years Months Days If less than one day

6 3 4 24 hrs. min.

9. Birthplace Chapter St. Marys Maryland

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farming

12. Name Thomas Morgan

13. Birthplace St. Marys Co

14. Maiden name ()

15. Birthplace ()

16. Informant Johnson Morgan

Address Helen by

17. Burial Date thereof July 12-1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Joseph's Cemetery

Location Morgan's 290

18. Funeral director W. C. Mattingley

Address Leonardtown MD

19. (Data rec'd by registrar) 19. 86 Date received

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys

City or town Helen (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1946 at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1 1946 to July 10 1946 and that I last saw h. m. alive on Feb 12 1946 19. 46

Immediate cause of death

Cardio-Renal Vascular Disease

Due to

Diabetes mellitus

Due to

Other conditions no

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results None done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

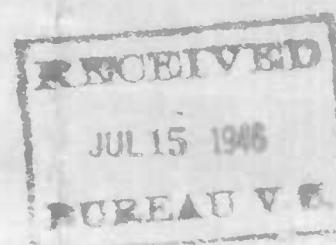
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Gladysin C Welch M. D. or other

Address Chaplin MD Date signed July 10 1946



PLEASE WRITE PLAINLY, WITH BLACKADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

117272

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Vincent A. Wise

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married

6. (b) Name of husband or wife

Mary A. Wise

7. Birth date of deceased (mo. day, yr.)

Jan 5 1877

6. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day

69 6 36 hrs. min.

9. Birthplace

Holly Wood St. Mary's Maryland

(Town, county, and state)

10. Usual occupation

merchant

11. Industry or business

Police B. Wise

12. Name

St. Mary's Co

13. Birthplace

Mary S. Martin

14. Maiden name

St. Mary's Co

15. Birthplace

Mary S. Martin

16. Informant

Mrs. Mary B. Wise

Address

Holly Wood Md

17. Burial

Date thereof Aug 2 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St. James Cemetery

Location

Holly Wood Md

18. Funeral director

W. H. Mattingly & Sons

Address

Holly Wood Md

19. (Date rec'd by registrar)

8/1/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County St. Mary's

City or town

Holly Wood (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 31 1946, at 3:40 P.M.
I certify that death occurred on the date above stated; that I attended deceased from
July 26 to July 31 1946
and that I last saw her alive on July 30 1946

Immediate cause of death

Arterio - sclerosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, Industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank A. Cawley
Date signed 8/1/46

M. D. or other

